

Case Number:	CM15-0110132		
Date Assigned:	06/16/2015	Date of Injury:	11/01/2008
Decision Date:	07/15/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/08/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Arizona, California

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 40 year old male, who sustained an industrial/work injury on 11/1/08. He reported initial complaints of back and shoulder pain. The injured worker was diagnosed as having chronic low back pain and lumbar radiculopathy. Treatment to date has included medication, ice packs/hot showers, physical therapy, muscle stimulator, chiropractor treatments, home exercise program, epidural injections (2), surgery (anterior retroperitoneal exposure L5-S1, anterior lumbar discectomy, bilateral foraminotomies, and complete decompression of the neurologic elements, partial carpectomy at L5-S1, anterior lumbar interbody fusion, anterior lumbar plating L5-S1. MRI results were reported on 11/5/13. X-Rays results were reported on 6/24/09, 8/4/10, 11/23/10, and 11/30/11. Currently, the injured worker complains of ongoing back pain. Per the medical examination on 12/15/14, the examination revealed moderate bilateral lumbosacral tenderness to palpation, limited range of motion in flexion at 70 degrees with normal extension, lateral flexion, and rotation, 4/5 weakness in the left lower extremity and depressed reflexes and pinprick sensation test, straight leg raise is positive in both legs at 30 degrees. The requested treatments include IF (interferential garment) unit with garment trial.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

IF unit with garment 2 month trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines IF unit Page(s): 118.

Decision rationale: According to the guidelines an IF unit is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. In this case, there was a plan for interventional procedures rather than a plan to return to work or exercise in combination with the IF unit. As a result, the request for the IF unit is not medically necessary.